LEGISLATIVE RESEARCH UNIT *Form LRU 191 – FY 17*

FEDERAL AID INFORMATION

I. IDENTIFICATION

SAI #s---Attach additional sheets if necessary									CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER CFDA # ☐☐.☐☐☐

Agency: Division(s) Receiving/Administering Funds	CUSAS/SAMS # - Division # ☐☐☐☐☐
Federal Public Law No.	**Program Title:**
Administering Federal Agency and Office:	

II. DESCRIPTION

1. Type of Program
- ☐ Formula Grant
- ☐ Project Grant
- ☐ Contract
- ☐ Other (specify): _____

2. Type of Payment Mechanism:
- ☐ "Draw down" as required
- ☐ Reimbursement – portion of expenditures
- ☐ Regular installment
- ☐ Lump sum in advance
- ☐ Other (specify): _____

3. Federal funds are deposited in the following State Treasury Fund(s)
Treasury Fund No. _____ Treasury Fund Name _____
Treasury Fund No. _____ Treasury Fund Name _____

4. Were federal funds appropriated by the General Assembly?
FY 2016 ☐ Yes ☐ No
FY 2017 ☐ Yes ☐ No

5. Under what authority does your agency receive and expend these funds?
ILCS: Chapter _____ Section _____

6. Matching Requirements:
State match required?
☐ Yes ☐ No

State match required to be
☐ Cash ☐ In Kind

If Yes, specify:
☐ Federal %
☐ State %
☐ Local %

FY 2016 %	FY 2017 %

Source of State match:
Treasury Fund No. _____ Treasury Fund Name _____
If no local match is indicated, does the program allow use of local funds in lieu of State match?
☐ Yes ☐ No

7. Indirect Costs: Is your agency operating under a federally approved indirect cost reimbursement plan?
☐ Yes ☐ No
If YES, will the reimbursement amount be set by:
- ☐ an indirect cost rate?
- ☐ a cost allocation plan?
- ☐ a negotiated lump sum for overhead costs?

Estimated indirect costs to be recovered from the federal government:
FY 2016 $_____ FY 2017 $_____

8. Source of Funds:
- ☐ Direct from the federal government
- ☐ Indirect; through an intermediary (specify agency): _____

9. What would be the total cost to the State if federal funds available under this program were discontinued and the State assumed full financial responsibility?
FY 2016 $_____ FY 2017 $_____

10. Are some of these funds subgranted to other STATE agencies?
☐ Yes ☐ No

If YES, list probable State Agency CUSAS/SAMS #'s and amounts:

Agency	Amount
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$

11. Are some of these funds subgranted to local governments?
☐ Yes ☐ No

12. Planning and Reporting Requirements:
Does the granting agency require planning document?
☐ Yes ☐ No
Does the granting agency require other reports?
☐ Yes ☐ No If YES, complete items below:

a. Evaluation Report
☐ Annual ☐ Quarterly ☐ Monthly ☐ Other

b. Financial Report
☐ Annual ☐ Quarterly ☐ Monthly ☐ Other

c. Performance Report
☐ Annual ☐ Quarterly ☐ Monthly ☐ Other

d. Other (please specify)

III. FISCAL INFORMATION

IN THOUSANDS OF DOLLARS

PROGRAM FISCAL INFORMATION *(in thousands of dollars)*	FY 2016 (Actual)	FY 2017 (Estimated)
13. Formula Allocation:		
Amount of funds legally available from allocation. (Enter NA if not a formula grant.)		
14. Available Awards:		
A. Amount of federal funds awarded.		
B. Amount of federal funds carried over from previous years.		
C. TOTAL federal funds available for expenditure (A + B).		
15. Federal Fund Expenditures:		
A. Amount of federal funds expended for your agency's activities.		
B. Amount of federal funds subgranted to other state, local, or private agencies.		
C. TOTAL federal funds expended (A + B).		
16. State Expenditures:		
A. Amount of state funds expended as matching requirement.		
B. Other State funds expended for support of program.		
C. TOTAL state funds expended (A + B).		
17. Cash Receipts:		
A. Cash receipts deposited in first trust fund listed in Part II, Sec. 3, page 1.		
B. Cash receipts deposited in second trust fund listed in Part II, Sec. 3, page 1.		

IV. PROGRAM INFORMATION

Please provide information on the State programs and services provided with these funds. For example, the Preventive Health Services Block Grant supports programs for hypertension, rape crisis centers, and grants to local health agencies. Area served might be "statewide" or a particular target area such as "city" or "county." Also provide an estimate of the number of persons/clients served by each program.

State Program Name	# of Persons Served	Area Served
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Survey completed by:	
Name & title	Phone: (Business & Fax)
Agency and address	e-mail address

Comments: